Group Dynamics:
Theory, Research, and Practice

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Cultural Ruptures: Addressing Microaggressions in Group Therapy

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Objective: Because therapy groups represent social microcosms, social dynamics from outside of the group play out in the context of the group, including those related to power, privilege, and oppression, like microaggressions. Left unaddressed, microaggressions have negative impacts on the health and well-being of the targets, perpetuate systemic inequity, and present a particularly destructive form in rupture to the group. The objective of this practice review is to help prepare group therapists to address the cultural ruptures known as microaggressions. ***Method:*** We first briefly review the literature on microaggressions, including those that occur in individual and group psychotherapy, to highlight the importance of addressing microaggressions when they occur. Next, we review the literature related to multicultural competence, multicultural orientation, difficult dialogues, and bystander intervention to suggest practice recommendations for addressing microaggressions in group therapy at the therapist and group levels. We also present a case example to illustrate these recommendations in practice. ***Results:*** Our practice recommendations highlight actionable ways for group therapists to proactively prepare to address microaggressions both before and outside of the group and in the here-and-now. ***Conclusions:*** Microaggressions are likely to occur in the social microcosm of the group and addressing microaggressions in groups is essential. Group leaders can proactively prepare themselves and the group to address microaggressions as they occur to minimize harm to the targets and the group-as-a-whole.

Highlights and Implications

- Microaggressions, or subtle discriminatory slights that perpetuate inequality, are likely to emerge in the context of the social microcosm of group therapy, as they have been found to in individual therapy.
- Microaggressions present challenging cultural ruptures in group therapy, but training and preparation may help the therapist and group successfully negotiate these ruptures.
- Therapists can develop multicultural competencies and espouse a multicultural orientation (MCO) to effectively identify and address microaggressions in the context of the group, including through formal trainings.

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- At the group level, the group can also set norms that encourage and support difficult cultural dialogues, develop a group MCO (i.e., their cultural humility, and willingness and comfort in addressing cultural issues, like those presented by microaggressions), develop capacities for bystander intervention, and create corrective emotional experiences in response to cultural ruptures.
- Additional empirical research is needed on microaggressions in group therapy, as well as the preparation of the therapist and group to successfully negotiate these cultural ruptures as they occur.

Keywords: cultural ruptures, group therapy, microaggression, multicultural competence, multicultural orientation

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The multicultural counseling literature has made significant advances in guiding therapists working with clients with diverse sociocultural identities. For example, literature has attended to the development of multicultural competencies, social justice issues, and the ways in which systems of power and oppression influence therapeutic processes and outcomes (Arredondo, 1999; Moradi, 2017; Sue, Sue, et al., 2019). One facet of this work includes the examination of microaggressions in psychotherapy (Johnston & Nadal, 2010; Pierce, 1970; Sue et al., 2007). When left unaddressed, microaggressions in psychotherapy perpetuate culturally oppressive systems by reinforcing historic distrust of therapy and marginalization (Kennedy et al., 2007; Moleiro, 2018). It is necessary for therapists to offer socially just services by acknowledging when microaggressions occur and working to reduce the frequency and impact of microaggressions in therapy. Although there has been a great deal of guidance in repairing cultural ruptures related to microaggressions in individual therapy, less attention has been paid to the occurrence and impact of microaggressions in therapy groups, with some exceptions (e.g., Belcher Platt, 2017; Kivlighan et al., 2020). This is an important endeavor as microaggressions can arise in specific and complex ways within-group settings. This article briefly discusses the literature on microaggressions, reviews research on microaggressions in individual and group therapy, and offers practice recommendations based on this research for how to address microaggressions in group settings.

The term microaggression was first used by Pierce (1970) in the wake of the civil rights movement to refer to subtle discriminatory statements or acts that were seemingly innocuous. Sue et al. (2007) expanded this definition in a taxonomy of microaggressions, identifying specific types of these "commonplace verbal, behavioral, or environmental" injustices (Sue et al., 2007, p. 271). This taxonomy includes Microassaults (explicit derogatory attacks that are intended to harm and oppress), microinsults (insensitive demeaning of racial identity), and microinvalidations (acts that undermine, disaffirm, or exclude the lived experience of a person from a marginalized group). Examples of microaggressions include racial and other identity-based slurs, being treated as a second-class citizen, assumptions based on perceived cultural characteristics, denial of cultural biases or the lived experiences of those who hold marginalized identities, exoticization and objectification, the use of racist environmental symbols (e.g., confederate flags and swastikas), and pathologizing of cultural identity (Johnston & Nadal, 2010; Owen et al., 2018a; Sue et al., 2007). These acts are designed to further oppress those who hold marginalized identities and are enactments arising from culturally monolithic narratives constructed by dominant groups (e.g., in the U.S. context, this refers to Eurocentric narratives of white people, cis-gender men, heterosexual people, Christians, able-bodied people, and wealthy people) to maintain delineations of social capital constructed around cultural identities like race.

Often, microaggressions go undetected by the perpetrator as they are formed from inherited socialized biases (Sue et al., 2007), but their impacts on recipients can be devastating (Solorzano et al., 2000). Research has found that microaggressions have profound negative effects on psychological outcomes, such as increased self-doubt, decreased self-esteem, and feelings of embarrassment, worthlessness, shame, and anger (Johnston & Nadal, 2010; Nadal et al., 2015;

Solorzano et al., 2000; Sue, 2010; Weber et al., 2018) and their cumulative and pervasive effects contribute to depression, substance abuse, and increased levels of distress (Nadal et al., 2014, 2015; Schoulte et al., 2011; Sue et al., 2007; Wang et al., 2011).

Microaggressions in Individual Psychotherapy

Davis et al. (2016) argued that microaggressions can be viewed as a specific type of rupture in therapy. Given their own socialization in an inequitable society, therapists must remain aware that they are likely to perpetrate these cultural ruptures in session and are responsible for addressing them. For example, in a sample of 2,212 racial and ethnic minority (REM) clients, 53%–81% reported experiencing one or more microaggression during psychotherapy (Hook et al., 2016). Similarly, in a qualitative study of the experience of sexual orientation microaggressions, Shelton and Delgado-Romero (2013) found that lesbian, gay, bisexual, and queer participants experience microaggressions from their therapist, leaving them with negative emotional reactions, feelings of invalidation, and questions about the effectiveness of their treatment. In another study, Owen et al. (2014) found that 53% of clients in their sample had experienced at least one racial microaggression and 76% of those participants reported that it was never addressed in the session. Similarly, in an experimental study, Owen et al. (2018a) assigned therapist participants to one of two conditions: One in which they watched a video of a counseling vignette that included three racial microaggressions, or a control condition in which they watched a video with no racial microaggressions. Interestingly, while participants in the microaggression condition rated the therapist as less sensitive, culturally comfortable, and humble, and having missed more cultural opportunities, only about half of the participants could accurately identify one of the three microaggressions that occurred in the vignette. Taken together, this research suggests that microaggressions occur regularly in psychotherapy and that these cultural ruptures often go undetected and unaddressed (Davis et al., 2018; Shelton & Delgado-Romero, 2013; Spengler et al., 2016).

Extensive research demonstrates that microaggressions significantly hinder psychotherapy processes and outcomes (Chang & Yoon, 2011; Crawford, 2011; Davis et al., 2016; Gaztambide, 2012; Owen et al., 2011a, 2017, 2018b; Spengler et al., 2016; Sue et al., 2007). These cultural ruptures in therapy have been found to result in early termination, low treatment utilization, negative treatment outcomes, feelings of anger, shame and being misunderstood, and weak therapeutic alliance (Crawford, 2011; Davis et al., 2016; Gaztambide, 2012; Owen et al., 2011a, 2017; Spengler et al., 2016). The power of microaggressions is in their invisibility to perpetrators and targets alike (Sue et al., 2007); without awareness of their occurrence in psychotherapy and insight into their impacts, these ruptures transpire in a manner that undermines the therapeutic relationship and safety and trust between client and therapist.

The inherent power dynamics in therapy make addressing these ruptures difficult, despite the necessity to do so. The client may experience their therapist as an authority figure, whom they feel they cannot question (Sue et al., 2007). Clients may then censor their negative reactions to microaggressions in therapy as a protective strategy and defer to the practitioners' expertise (Chang & Yoon, 2011). Furthermore, because microaggressions often arise from unconscious biases, therapists may unwittingly impose their own cultural worldview on clients while simultaneously pathologizing or diminishing the cultural values of their clients. This presents a unique challenge to practitioners and calls on psychotherapists to engage in constant self-reflection so they can address microaggressions when they occur.

Microaggressions in Group Therapy

Whereas the occurrence and impact of microaggressions are well documented within the individual psychotherapy literature, as noted earlier there is a paucity of research on the implications of microaggressions in group therapy. In fact, a PsycINFO search for the keyword "microaggression" at the time of this writing yielded 137 hits. However, adding the keywords "group therapy," "group counseling," or "group psychotherapy" yielded none. Group theorists and researchers *do* recognize, however, the need to implement culturally and socially just practice in group-based psychosocial treatments that focus on systems of power and oppression through a multicultural lens (Burnes & Ross, 2010; Chen et al., 2008;

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Kivlighan & Chapman, 2018). Recent studies have initiated efforts to gain a deeper understanding of the importance of cultural processes in group psychotherapy, and the impact of microaggressions in therapy groups (Belcher Platt, 2017; Kivlighan et al., 2019a, 2019b, 2020).

Belcher Platt (2017), for example, examined racial–cultural events (RCEs) in group therapy utilizing a grounded theory approach. Semi-structured interviews were conducted with 17 participants about their experiences of RCEs in group therapy and the presence and impact of microaggressions. Findings suggested that not only were microaggressions present in therapy groups, but the processing of their occurrence was impeded by group discomfort, group composition and dynamics, and external experiences of RCEs. Furthermore, RCEs were less likely to be discussed and even when discussed, these efforts were not necessarily helpful to group members. These findings are further supported by a recent quantitative analysis of microaggressions in therapy groups. Specifically, Kivlighan et al. (2020) examined the rate and impact of microaggressions in therapy groups, as well as the reparative role of the group's MCO on cultural ruptures (group MCO is discussed in detail below). Similar to the findings of Belcher Platt (2017), results suggested that racial microaggressions negatively impacted members' perceptions of cohesion in therapy groups that were perceived to be low in comfort engaging cultural issues.

Overall, research on microaggressions in individual and group psychotherapy demonstrates the pervasiveness of these cultural ruptures, the high likelihood that these cultural ruptures go unaddressed, and the consequences of these ruptures on therapeutic processes and outcomes. There remains, however, a significant need to establish appropriate practice recommendations for group therapists to ensure that services are culturally inclusive, affirming, and promote social justice through addressing cultural processes that attend and respond to systems of power and oppression by challenging oppressive enactments. In the remainder of the manuscript, we review the literatures on factors that impede addressing microaggressions, as well as those that may facilitate this work. Based on these literatures, we propose a set of practice recommendations (see Table 1), which we illustrate through a briefcase example.

Challenges in Addressing Microaggressions in Groups

Understanding some of the challenges associated with addressing microaggressions might help prepare group therapists to overcome these challenges and engage in meaningful and productive dialogue. The literature on microaggressions, broadly, highlights some of the challenges in addressing them. Sue (2010), for example, suggests that microaggressions are subtle "slights" rooted in implicit bias, which means that the perpetrator and others in the group (particularly those who were not targeted) may be unaware of them. It also means that they are more resistant to change (Sue, 2010). Sue (2010, 2015) also noted that addressing microaggressions often evoke a sense of fear, particularly for those in dominant groups. These fears include the fear of being oppressive (e.g., racist, sexist, and heterosexist), the fear of acknowledging one's own oppressive attitudes and/or behaviors, the fear of acknowledging one's own privilege, and the fear of taking personal responsibility to address oppression.

Discussing microaggressions may also violate social norms because they are tied to our identities and potentially emotionally charged experiences with privilege, power, and oppression. For example, Sue (2015) points out that talking about race and racism can violate the colorblindness protocol in the U.S. that dictates that we should not talk about race or other differences because we are all the same. In reality, colorblind ideologies that evade talking about race and power are "ultramodern" forms of racism (Neville et al., 2013). In fact, Neville and colleagues note that the evading discussion of color and power differences is, in itself, a form of microaggression that invalidates the lived experiences of people of color. The dominant ideology that the U.S. meritocracy is often attached to the colorblindness protocol, in which effort is proportionately rewarded, regardless of one's social identities (Neville et al., 2013) when, in fact, the persistence of identity-based inequities (e.g., Bhutta et al., 2020) highlights that this is a myth. Sue (2015) notes that talking about microaggressions also violates politeness and academic protocols for other everyday social interactions, though in the context of group therapy, these protocols are violated in other ways, too (Yalom & Leszcz, 2020).

When faced with these challenges, there may be a reticence to discuss microaggression

Table 1
Practice Recommendations for Addressing Microaggressions in Group Therapy

	Therapist level
Pregroup/ongoing	Continually strive to build one's multicultural competencies (Sue et al., 1992), including knowledge and awareness of privilege and oppression at the individual, institutional, and systemic levels, both formally (e.g., classes, continuing education, and workshops) and informally [e.g., engaging in dialogue across difference, reading research and books on cultural issues, broadly, and cultural communications, specifically (e.g., DiAngelo, 2018; Sue, 2015)]. Develop a positive multicultural orientation (e.g., Owen, 2013): Gain an understanding of the behavioral, affective, cognitive, and somatic ways of being during cultural dialogues, and strive to develop a curious and open orientation when engaging and addressing issues of diversity. Reflect on one's own power, privilege, and/or oppression (e.g., related to social identities and therapist role) and how they impact the work one does in therapy and how one is perceived. Seek out opportunities to engage in cultural dialogues oneself. Develop an understanding of the potential challenges to difficult cultural dialogues (e.g., common negative emotions that may impede them), both to know what to expect and prepare group members and normalize the process; expand one's own window of affective tolerance to handle and attend to the intensity of emotions that might arise. Familiarize oneself with frameworks for addressing microaggressions (e.g., Sue, 2010) and "microintervention strategies" (e.g., Sue, Alsaidi, et al., 2019). Assess the physical environment of the group (Belcher Platt, 2017). Who/what is represented in artwork, photographs, informational materials, and books? What messages might be implicitly or explicitly sent as a result (e.g., related to who is welcome, who is valued)? Formally or informally assess group members' racial–cultural identity development (Belcher Platt, 2017). What have been their experiences/difficulties/strengths/goals in cross-racial/cultural interactions? How comfortable do they feel addressing a difficult cultural interaction? What are their expectations of the therapist in the event of a microaggression or difficult cross-cultural interaction?
	Group level
Early sessions	As part of one's attention to the group climate and the development of cohesion, explicitly name visible identities and power dynamics, and invite people to name invisible identities and power dynamics Educate group members about the likelihood of cultural ruptures and proactively share strategies for addressing them [e.g., share Sue, Alsaidi, et al. (2019) useful table of "microintervention strategies" (pp. 136–138)]. Engage in metacommunication to proactively develop group norms for difficult cultural dialogues; share that research (and experiences) suggests these conversations are hard and are often avoided. Set a norm that the group will engage in these dialogues. Model and facilitate the discussion of cultural issues, broadly. Help members explore the richness of race, which often gets lost when the race is altogether avoided because of racism and other forms of oppression (i.e., acknowledge that difference is not a problem, oppression is, so difference need not be avoided). Develop the group's multicultural orientation: Discuss the concept of cultural humility and model it, set a norm that the group can and should attend to cultural events and ruptures and model seeking cultural opportunities that arise, use immediacy and self-involving statements about one's own emotional and somatic experiences of a cultural event as they occur within the group. Attend to the group as a social microcosm/find cultural opportunities in the here-and-now. How is racism (and other forms of oppression) at play? How is the group replicating problematic social dynamics and inequity?
When the rupture occurs	Make the invisible visible when a microaggression occurs; illuminate the process. Disarm the microaggression: Make sure the target(s) are supported and attend to others with marginalized identities who experience collateral harm (e.g., a microaggression directed at a Black group member may serve as a warning sign to other group members of color that the group is not safe); serve as an intermediary for attacks. Educate the perpetrator. In group therapy, this includes "educating" about why/how the microaggression perpetuated oppression and the impact of the microaggression on the target(s) and the group. Help perpetrators increase their affective tolerance (e.g., manage shame, defensiveness) and reduce their fear of annihilation at receiving feedback (e.g., resisting the need for retaliation). Seek to provide a corrective emotional experience related to the cultural rupture, as one might with other interpersonal issues. Brown (2016) provides an excellent "Procedural Guide" to fostering corrective emotional experiences that can be applied to corrective emotional cultural experiences.

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occurrences, the systemic issues reflected in them, and/or the potential rupture caused by them. The perpetrator (and others from the dominant group) may react with negative emotions such as defensiveness, anger, and anxiety; and they may act to deny or dilute what has been said in order to avoid these emotions (and challenges to their worldview; Sue, 2013). At the same time, those from the targeted group may feel offended, hurt, invalidated, and in need of support (Sue, 2013). Chen et al. (2003) further highlighted the challenges with intercultural dialogues in the context of group therapy, noting that in addition to the anxiety experienced in these dialogues, there is also uncertainty.

Addressing Microaggressions in Group Therapy

Further complicating addressing microaggressions in group therapy is the fact that groups are complex, multilevel systems. Therefore, addressing microaggressions in the group may also involve multi-level tactics. To this end, we discuss considerations for addressing microaggressions at the therapist and group levels. We offer the following vignette to illustrate an implementation of these considerations at each level. This is a fictionalized example, inspired by the research of Belcher Platt (2017).

> A group member who identifies as a cisgender, Black man joins a Dialectical Behavior Therapy (DBT) skills group at a psychology clinic operated by a large, predominantly white university in his city. The group is open to members of the metropolitan community and is co-facilitated by a white woman professor and a BIPOC woman doctoral trainee from the university's psychology program. As the new member walks through campus to find the psychology clinic, he is questioned by several professors before ultimately being stopped by campus police who were alerted by others. Campus police inquire about his presence on campus and follow him to the clinic. During introductions, after some comments about the unusualness of his name and some members' difficulty pronouncing it, the new member is quiet. A member nudges the new member by saying that he'll get more out of the group if he is engaged. The member reluctantly shares that he is unnerved about being stopped by campus police and, as a result, feels out of place on the campus and is worried about returning out of fear of a recurrence, especially given what's happening in their city with police. A white, cisgender member, with a visible disability, extends herself by offering that she is also made to feel out of place on campus and navigating campus is difficult for her as well, so she understands. A white, cisgender man assures him that if he isn't doing anything wrong, he has nothing to worry about and he's never had any issues with campus or city police. The BIPOC trainee intervenes to validate that it must have felt scary to be stopped. The white male member chimes in again and asks the white professor co-therapist to affirm that this is being blown out of proportion.

The Group Therapist

Preparation to address microaggressions in group therapy needs to begin outside of the group itself. Indeed, the therapist is not immune to some of the challenges highlighted above. For example, they have their own implicit biases and emotional reactions to talking about issues related to social identities, based on their own group memberships and experiences with associated forms of privilege and oppression. Therefore, it is important for therapists to develop both multicultural competencies (Sue et al., 1992) and an MCO (Owen et al., 2011b).

Multicultural Competence. Sue et al. (1992) set forth a guide for conceptualizing multicultural competencies that includes awareness of cultural beliefs and attitudes (i.e., awareness of their own cultural background, the socialization messages they received, the limitations of their competence, comfort with a difference), knowledge of cultural groups (their own and others) and issues (including privilege and oppression), and skills (e.g., being able to engage in a wide variety of culturally appropriate interventions). Based on his work on multicultural competencies (e.g., Sue et al., 1992), Sue (2010) distilled several basic objectives for therapists in dealing with microaggressions, including: "making the 'invisible' visible, establishing expertise and trust, and providing appropriate services to diverse populations" (p. 277). To meet these objectives, he pointed to the importance of therapists doing their own work (outside of the therapy they conduct). For example, therapists should work to examine their own values, biases, assumptions, and socialization and how they impact their work. Sue suggested this will allow them to work to avoid perpetuating cultural oppression themselves. Sue provided these suggestions presumably for those practicing individual therapy, but he notes that his suggestions, "are equally applicable to interpersonal interactions of nearly all forms" (p. 276). We agree and believe that his general suggestions are a good starting point for group therapists, too.

Sue (2010) went on to suggest other principles for therapists to develop multicultural

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competencies that will help them deal with and avoid being a perpetrator of microaggressions, including learning from those from different social identity groups, especially "healthy and strong people" from those groups (as opposed to negative and stereotypic portrayals that may be seen in the media). He also suggested that therapists should seek out new experiences with diverse people in their lives, be vigilant of their own biases and fears, and commit to social action aimed at creating a more equitable society in their own lives.

Sue et al.'s (2010) research examining white counseling psychology students' experiences talking about race reinforces the need for therapists to do their own work. When asked about strategies their instructors use to facilitate productive dialogues on race and racism, students noted that an instructor's "openness and acknowledgement of their own biases and feelings" (p. 211) was one helpful strategy. The other useful strategies that the participants noted were validating feelings and facilitating discussion of emotions in the here-and-now, whereas being passive and not intervening was found to be unhelpful, and led to feelings of invalidation and instructor incompetence. While their study was not a study of group therapy, it does provide some suggestions for facilitating the type of difficult dialogue about power, privilege, and oppression that a microaggression in group therapy elicits.

Revisiting the vignette, both group therapists could model self-awareness by naming their identities as part of their introduction to the new member and inviting other members to do the same. For example, they might say, "As we welcome our new member, as is our tradition, let's introduce ourselves and share our visible and invisible identities. We'll start . . . " Multicultural competence would also facilitate the white cotherapist addressing the white member's attempt to elevate her as the authority and for the cotherapists to model an exploration of their dynamic. For instance, "I notice that though my co-therapist spoke, you addressed me as the authority here to stop the conversation about his experience of racism and interactions with law enforcement. I wonder what made you look to me?"

The cotherapist could also use herself as an instrument to help him (and other members) explore their biases and the dynamic: "As we've discussed before, there is a common dynamic of denying or minimizing racism or silencing people around it. You and I, as white people, shutting down this conversation would recreate that. I did not use to understand much about other communities' experiences with police, but I have since learned different. What if you and I just listened and maybe tried to understand our new member's experiences?"

Additionally, the cotherapists could model egalitarianism. The white cotherapist could note, "She and I are co-therapists, and we learn from each other just as each member learns from each other. What she was saying was silenced but I think it'd be helpful for all of us if we went back to that." The BIPOC cotherapist could model self-advocacy, "I know this might feel like a difficult conversation, but I wasn't finished speaking and we weren't done hearing our new member share. After we are, maybe we can also explore what transpired just now?"

Therapist Multicultural Orientation. MCO has been examined in the individual therapy literature (Owen et al., 2011b) as a compliment to multicultural competence (e.g., Sue et al., 1992). The MCO framework acknowledges that one will never be fully multiculturally competent, as learning about oneself, one's culture, and the cultures of others entails a lifelong process. The MCO framework focuses on developing a "way of being" (Owen et al., 2011b, p. 274) that involves cultural humility (i.e., having a stance of openness and curiosity with regard to understanding cultural identities and issues), cultural opportunities (i.e., initiating or responding to conversations about cultural issues that come up), and cultural comfort (i.e., comfort in engaging in conversations about cultural issues) (Kivlighan et al., 2019a). Research suggests that MCO is related to important therapeutic processes, including the working alliance, and treatment outcome (Davis et al., 2018). Given that microaggressions often go unaddressed in therapy (e.g., Owen et al., 2014), therapists are missing cultural opportunities, perhaps because they are not aware that the microaggression has occurred and/or perhaps lack cultural comfort in processing the negative cultural events. Therefore, developing therapists' MCO may be particularly important to address microaggressions when they occur.

Kivlighan and Chapman (2018) applied the MCO framework directly to group therapists, noting that, "group therapists who are able to engage cultural humility, comfort, and seek

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cultural opportunities may be better prepared to establish culturally affirming and inclusive group environments, and reduce the possibilities for within-group experiences of oppression and sociopolitical inequalities" (p. 43). In their application of the MCO framework, they discussed how a group therapist's MCO can facilitate the opportunity to discuss cultural issues presented by a microaggression at the moment, with humility and comfort. (As discussed below, the application of the MCO in group therapy also extends to the group members' own cultural humility, cultural opportunities, and cultural comfort.)

While not designed within a multicultural competence or MCO, specifically, Lefforge et al. (2019) created a training model to help group therapists address microaggressions in the group that appears to attend to aspects of both. For example, their multimodal training includes a didactic component that reviews definitions and concepts from multicultural and social psychologies (e.g., defining microaggression, implicit bias, and intersectionality; reviewing social dominance theory) to build cultural knowledge (an aspect of multicultural competence), which may help group therapists identify and understand the impact of microaggressions. They also include videos and a fishbowl role-play activity to illustrate the concepts discussed in the didactic portion of the training with the goal of helping trainees "gain comfort with dialoguing about these topics" (p. 15). Lefforge and colleagues noted that "Responding therapeutically to microaggressions requires cultural humility, perspective taking, and advanced interpersonal skills" (p. 23). Thus, while empirical data is needed to assess whether the training actually increases a group therapist's multicultural competence and MCO, aspects of both of these concepts (i.e., knowledge, skills, awareness, cultural humility, cultural opportunities, and cultural comfort) appear to be important parts of the training and desired outcomes.

We now return to our vignette. Informed by their MCO, during introduction the cotherapists might inform the new member, and remind the existing members, about the groups' norms around addressing identities, dynamics, and interactions. For example, "Although you've met us already during the pre-group interview, we want to reintroduce ourselves along with the rest of the group. In this group, we believe it is important to name our identities and put words to how our identities and experiences show up here in group."

The cotherapists would also address the microaggression, assumption of criminality, that occurred outside the group and that was repeated within-group by the fellow member's intimation that the police contact was warranted. "It sounds like a common experience related to your identity occurred on your way to group today. What you described sounds like a microaggression, where you're assumed to be out of place and up to no good. In this group, we talk about microaggressions and the harm they can cause so you can feel free to share more about that if and when you're ready." Additionally, the group could explore the system as the problem rather than the member and address the system's impact on members' access to and delivery of services.

Finally, the cotherapists could help the group join together around their various experiences of inaccessibility and inhospitality and contemplate solutions. "The sharing and supporting around these challenges in here between us is powerful and we'll continue to do that. We also feel we need to address these issues with campus officials. Although the challenges are different, it's important to us that everyone feel welcome and safe here, not just in group, but on campus as well."

The Group

Groups are complicated multilevel systems, of which the group therapist is but one piece. Groups are social microcosms that represent the world outside of the group when it comes to both individual social behaviors (Yalom & Leszcz, 2020) and larger social dynamics (Chen et al., 2003). This means that microaggressions are likely to happen in group therapy as they do in everyday life, and equally likely to go unaddressed, which could have the same deleterious consequences on the well-being of individuals and the group. Sue et al. (2007) called microaggressions "a barrier to clinical practice" (p. 280), noting that a strong therapeutic alliance is necessary for therapeutic work to occur and when a therapist commits a microaggression in individual therapy, then, the rupture can damage the therapeutic relationship. Given that cohesion in group therapy is an analog for the therapeutic relationship in individual therapy (Yalom & Leszcz, 2020), unaddressed microaggressions run the risk of damaging the cohesion in a group (Kivlighan et al., 2020).

Unlike individual therapy, however, the microaggression may be perpetrated by the group leader or any of the group members, and likely will have an impact beyond the targeted individual. Therefore, it makes sense that the whole group would be involved in addressing the microaggression. Group literature provides some guidance that may help group therapists in engaging in these difficult dialogues, promoting a group MCO, and setting a norm around bystander intervention within the group.

Group Multicultural Orientation. Kivlighan and Chapman (2018) suggested that therapists can assume and model an MCO as early as the pregroup preparation stage. This sets a norm for addressing cultural opportunities within a group, which will be important when the group is presented with the opportunity to address a microaggression that has occurred. Kivlighan et al. (2019a) further expanded on the notion of a group MCO, focusing not just on the cultural humility, prioritization of cultural opportunities, and cultural comfort of the therapist, but also of the group members themselves. Specifically, Kivlighan et al. (2019a) developed and validated the Multicultural Orientation Inventory-Group Version to examine these processes as perceived by the group members about their group. Using this scale, they found that cultural comfort and (missed) cultural opportunities were associated with group processes and group member improvement. These findings were further substantiated by Kivlighan et al. (2019b) study that investigated the relationship between cultural comfort and cultural concealment in 49 therapy groups for white and REM clients. Findings indicated that members' perceptions of the group's cultural comfort was positively related to their improvement and negatively related to their cultural concealment for members of color, but not white members. By helping foster a group MCO through modeling and establishing group norms that help group members identify cultural opportunities, including those presented when a microaggression is enacted, the group members, themselves, can become an important part of addressing microaggressions in group therapy. In fact, members' perceptions of their group cultural comfort have been found to buffer the negative impact of microaggression on perceptions of cohesion (Kivlighan et al., 2020).

The cofacilitators in our vignette could invite the group to consider the microcosm: "Now that we've introduced ourselves and named some of our identities. Maybe we could explore our first responses to our new identity as a group? What's our experience being in relationships with people with the identities in the room? What identities seem to be in the majority? What identities seem to be in the minority? How is this different or similar to our experiences outside the room? What worries and hopes do we have about our identities and interacting?"

Group Norms for Difficult Dialogues. In addition to fostering a group MCO, other norms can be established that can help address microaggressions when they occur. There is a growing body of interdisciplinary research on difficult dialogues, including those that happen in group settings and those that involve issues related to privilege, power, and difference that can help guide group therapists. Dialogue is a specific form of purposeful communication in which the goal is the development of a shared understanding of the other, from their perspective, rather than to win or persuade others that one is right, as in debate (Bohm, 2010; Flick, 1998).

In his book, *On Dialogue*, Bohm (2010, p. 16) said that dialogue is not therapy in that the goal is not to "cure" an individual. Instead, he cites his friend, Patrick de Mare, who called dialogue "sociotherapy" because the group is a microcosm of society, and so the "cure" is at the societal level. More recently, though, others have suggested that there are strong connections between dialogue and group therapy (e.g., Chen et al., 2003; Khuri, 2004; Moss et al., 2017). For example, Moss et al. noted that many of the tenets of group therapy (e.g., Yalom & Leszcz, 2020) are inherently part of intergroup dialogue, a specific group intervention designed to bring together individuals across social identity groups for sustained, face-to-face dialogue about social identities and social issues like systemic oppression and privilege. Both interventions, for example, include the processing of personal and cultural experiences and working through challenging emotions and conflict. Cohesion is also an important aspect of both types of the group (e.g., Moss et al., 2017; Muller & Miles, 2017), and is necessary for a productive dialogue about cultural issues, particularly those presented by microaggressions.

Given these connections between group therapy and intergroup dialogue, and the fact that intergroup dialogue facilitation involves the

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development and use of group facilitation skills and multicultural and social justice knowledge, skills, and awareness, Moss et al. (2017) suggested that intergroup dialogue facilitation training should be considered as part of counselor education. White et al. (2018) similarly argued for the usefulness of intergroup dialogue facilitation training as a part of therapist training, based on the results of their qualitative exploration of the impact of an intergroup dialogue facilitation course in an American Psychological Association accredited doctoral program in counseling psychology. Participants reported that training in intergroup dialogue facilitation increased both their group facilitation competencies, as well as their social justice competencies (e.g., their consciousness about social inequities; their ability and interest in acting as an ally and advocate).

Chen et al. (2003), for example, provided a "dialogic perspective" on diversity in group counseling that acknowledges that all groups are multicultural and so intercultural dialogue is necessary. In weaving together the literatures on dialogue, they astutely point out that intercultural dialogue involves anxiety and uncertainty, but that group therapy always requires some interpersonal risk (and interpersonal learning; Yalom & Leszcz, 2020). They also highlight the fact that attending to these difficult dialogues in the here-and-now can be an important part of providing a corrective emotional experience for group members, particularly those targeted by oppression, which extends to those targeted by microaggressions. They also noted that feedback is an important part of group therapy, which is inherently a part of addressing a microaggression. They further noted, however, the challenges associated with feedback around cultural issues, like microaggressions, particularly as they relate to power. Specifically, they noted that minority group members may also be reluctant to deliver corrective feedback.

Bohm (2010) said that dialogue requires "metacommunication," or communicating about how the group will communicate. Group therapists are in a good position for this type of metacommunication, given the explicit attention to pregroup preparation and the early establishment of group norms they already engage in. Engaging in metacommunication may help facilitate the group MCO by making explicit the norm that the group will take opportunities to address cultural issues, including microaggressions, in the here-and-now, and that they will be able to do so with more skill and comfort.

Returning to our vignette, one cofacilitator might say, "I sensed that you were hoping to help our new member feel less alone out there and in here. Your challenges are valid and similar in some ways but different in very important ways. Before we look at how they're similar, let's try to understand how they're different. Let's remain open to anything our new member may want to share and, in the meantime, can we try to tap into this specific experience of feeling unwelcome or suspicious because of your skin color?" After some processing around race, the cotherapists could expand to the member with a disability, "You shared that you experience being considered out of place and having difficulty navigating campus, did you want to share more about that?" After helping members fully empathize with that member's unique experiences, the conversation can increasingly broaden.

Bystander Intervention. A final body of literature that may help group therapists address microaggressions is that on bystander intervention. Early research on bystander intervention showed that, in groups, there is a diffusion of responsibility such that individuals are less likely to respond to an emergency than if they had been on their own (e.g., Darley & Latané, 1968; Latane & Darley, 1968). Other reasons for not intervening include the fear of retaliation, fear of losing relationships, and other negative consequences (Sue, Alsaidi, et al., 2019). Therefore, in order for an individual to intervene in an emergency when others are present, Latané and Darley suggested that the individual needs to (a) notice the event, (b) interpret the event as an emergency, and (c) assume some responsibility for intervening. Given that microaggressions are often subtle, and that research finds that therapists often miss them (Owen et al., 2018b), a bystander effect may be likely to occur without proper attunement to cultural processes. It also requires that the individual knows how to help. To that end, some organizations have begun using bystander intervention trainings designed to equip members to intervene and, ultimately, create a more inclusive environment (Scully & Rowe, 2009). These trainings may include scenarios designed to help build awareness of microaggressions and skills in responding in ways that "pivot" away from the

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prejudice and provide "microaffirmations" (Scully & Rowe, 2009, p. 4).

More recently, microaggression researchers have developed a framework for responding to microaggressions that can be used not only by bystanders, but also by targets' allies and targets (Sue, Alsaidi, et al., 2019). This framework includes four strategic goals: (a) making the invisible [microaggression] visible, (b) disarming the microaggression, (c) educating the perpetrator, and (d) seeking external reinforcement and support (Sue, Alsaidi, et al., 2019). Sue et al. suggested that some tactics for making the invisible visible include naming the metacommunication (i.e., the negative, prejudiced message being sent through the microaggression), challenging the stereotype, and asking for clarification. Making the invisible visible may be seen as analogous to "illuminating the process" (Yalom & Leszcz, 2020), which most group therapists already do. Sue, Alsaidi, et al. (2019) suggested that disarming the microaggression might involve expressing disagreement, stating one's values, making an exclamation (e.g., "ouch!"), or describing what is happening. Again, there are connections to the work that group therapists already do in terms of modeling immediacy, disclosing one's own reactions, and providing feedback. Educating the perpetrator, Sue and colleagues state, might include things like promoting empathy, pointing out commonalities, differentiating impact and intent, and providing support. Group therapists often provide information and attend to relational dynamics and group processes, and these skills can be applied in addressing microaggressions. The final strategic goal in Sue et al.'s framework, seeking external reinforcement and support, may look like a group therapist discussing the microaggression and seeking support from a clinical supervisor. Modeling of this framework by the group therapist in the group, or even explicit bystander intervention training, like metacommunication about dialogue, may help not only the group therapist feel prepared to address microaggressions in group therapy, but the group members as well.

During introductions, when several existing members expressed difficulty pronouncing the new member's name and commented on it's unusualness, an existing member, versed in MCO, would be equipped to recognize this as a microaggression: Pathologizing cultural values/styles. They could chime in, "I used to make similar comments about names that were new to me, but I've since learned that it's offensive because it makes people feel othered. It might feel more welcoming if we didn't do that and just practiced pronouncing his name correctly." Equipping members to intervene in the group can extend beyond the group. For example, in explaining allyship and exploring the earlier interaction with the white male member, the BIPOC cotherapist help him consider support instead of silence. For example, "Given that you never have any problems with the campus police, what would it feel like to meet our new member at the gate and use your privilege to walk together here so he feels as safe as you do?"

Conclusion

Groups are social microcosms (Chen et al., 2003; Yalom & Leszcz, 2020) and in the context of those social microcosms, microaggressions that replicate oppressive societal dynamics are bound to occur, as they do in individual therapy (Hook et al., 2016; Owen et al., 2018a; Shelton & Delgado-Romero, 2013). By developing their multicultural competencies (Sue et al., 1992) and an MCO (Owen et al., 2011b), therapists can be better prepared to address these cultural ruptures with humility and greater comfort. They can further work to establish group norms that create a climate that fosters difficult dialogues (Muller & Miles, 2017), including building the group's MCO (Kivlighan et al., 2019a) and providing models of bystander interventions (Sue, Alsaidi, et al., 2019) so that the therapist is not the only person capable of and comfortable with intervening.

In addition to recommendations for practice, there are several areas in need of future research to enhance our understanding of how to effectively address microaggressions as they occur within therapy groups. First, although there is a dearth of literature on effective multicultural group work, empirical research on the occurrence and impact of microaggressions in therapy, and group therapy especially, is in its infancy. Future research is needed to corroborate the findings of Kivlighan et al. (2020) and Belcher Platt (2017), as well as provide additional insights into strategies for addressing cultural ruptures in therapy groups. Specifically, future research is needed to document the occurrence of microaggressions in therapy groups, the effect of these cultural ruptures on

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group process and outcome, and effective strategies for addressing microaggressions over the course of the group. For example, the social microcosm theory of group therapy informs us of the presence of societal dynamics of oppression and privilege and implores us to address those dynamics as they play out in the group. Additional research is needed on how these inequitable societal dynamics play out in group therapy. Moreover, the majority of research on microaggressions has focused exclusively on the target, however as we note, microaggressions as they occur in therapy groups, may equally impact other group members who hold marginalized identities (i.e., bystanders). Therefore, research is needed to understand not only the effect of cultural ruptures on target members, but bystander members, as well as the group-as-a-whole. Second, microaggression detection studies have found that many therapists are unable to accurately detect microaggressions when they occur (e.g., Owen et al., 2018a). Given that leaders need to first detect the presence of a microaggression to effectively address these cultural ruptures, research is needed to examine how group therapists may enhance their ability to detect microaggressions when they occur. Lefforge et al. (2020) proposed a model for training group therapists in identifying and addressing microaggressions in group therapy, however this model and similar training strategies need to be empirically tested to identify best practices in training group therapists.

Third, research on how to address microaggressions can focus on strategies for both group leaders and members. In addition to leadership training, research is needed to understand how members may equally act to acknowledge and address cultural ruptures as they occur, and contribute to a positive group multicultural orientation. Lastly, and with any understudied construct in psychotherapy, measurement issues should be addressed to further examine microaggressions in psychotherapy. The majority of quantitative studies to examine microaggressions in therapy have utilized an adapted version of the Racial Microaggression in Counseling Scale (RMCS; Constantine, 2007), with limited attention to the psychometric properties of this measure. The detection of microaggressions is undoubtedly complex in research and additional measurement strategies are needed to empirically assess the complexity of cultural ruptures, particularly as they occur within a group setting. For example, there is a need for continued quantitative and qualitative explorations of microaggressions within-group therapy including therapists' and members' experiences and responses as well as mechanisms for successful repair of such ruptures. Additionally, exploration of the confluence of unique characteristics and sociopsychological phenomenon (e.g., diffusion of responsibility and bystander effect) of group therapy that would illuminate challenges to group therapists and members addressing systemic issues present in the here-and-now.

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Open Call for Evidence-Based Case Studies and Practice Reviews

Group Dynamics announces two new article types, to begin publishing in 2019: *Evidence-Based Case Studies* and *Practice Reviews*. The editor has issued an open call for submissions for both article types.

The goal of the *Evidenced-Based Case Studies* will be to integrate verbatim case material from the group with standardized empirical measures of process and outcome evaluated at different times during the life of the group, team or organization. That is, authors should describe vignettes highlighting key interventions, processes, and mechanisms regarding their specific approach in the context of empirical scales.

Meanwhile, the aim of the *Practice Review* is to clarify, as much as the current state of knowledge permits, what empirically-derived findings in a given area imply for practice. In this type of review article, the reviewer begins the process with the intent of deriving implications for practice from the research and theory. The key question of a *Practice Review* is: "What is the most likely relationship between these variables, and what does that relationship imply for the group practitioner?"

Examples and detailed guidelines for both article types can be found on the journal webpage, www.apa.org/pubs/journals/gdn. Authors who are interested in submitting either article type are encouraged to contact the editor.